Blackfalds Chiropractic Centre
5007 Broadway Ave.
P.O. Box 1510
Blackfalds, AB. T0M 0J0
Phone: 403-885-5808

Adult Health History

Date:_____

Patient's Name:_____Alberta Healthcare #:_____ Sex Gender

Mailing Address:_____City:_____ Province:_____ Postal Code: _____

Home#: _____Work#: _____ Cell#: _____

Email:_____ Would you like emailed? Receipts ◯ No ◯ Yes

Would you like reminders of your upcoming appointments by: ◯ Email ◯ Text

Date Of Birth: D/____M/____Y:_____Age:_____Married: How Many Children:_____Occupation:_____

Emergency Contact:_____Phone#:_____

Who may we thank for referring you to our office?_____Is this W.C.B? ◯ No ◯ Yes

1. What is the purpose of this appointment? ☐ Wellness ☐ Automobile Accident ☐ Other_____
2. What area(s)? ☐ Neck ☐ Shoulders ☐ Mid-back ☐ Low-back ☐ Hips ☐ Other_____
3. Where? ☐ Left ☐ Middle ☐ Right ☐ Front ☐ Back ☐ Other_____ Date symptoms appeared:_____
4. How long ago did symptoms first start?: ☐ Hours ☐ Days ☐ Weeks ☐ Months ☐ Years ☐ Chronic on /off
5. Rate the severity of your symptoms: ☐ Mild ☐ Moderate ☐ Severe
6. Did they start: ☐ Gradual or ☐ Suddenly
7. Describe your symptoms ☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Stabbing ☐ Deep ☐ Shooting ☐ Other:_____
8. Do your symptoms: ☐ Come and Go or ☐ Stay Constant
9. Do you experience tingling or numbness in: ☐ Shoulder ☐ Hips ☐ Arms ☐ Knees ☐ Hands ☐ Feet ☐ Legs ☐ Elbow
10. Are your symptoms worse in the: ☐ Morning ☐ Evening ☐ No change
11. What aggravates your condition: ☐ Stress ☐ Activity ☐ Lifting ☐ Standing ☐ Sitting ☐ Working ☐ Sleeping ☐ Other_
12. What Relieves your Symptoms:
    ☐ Rest ☐ ice ☐ heat ☐ lying ☐ Adjustment ☐ Massage ☐ Standing ☐ Sitting ☐ Medication ☐ Nothing
13. Is your condition interfering with your: ☐ Quality of life ☐ Work ☐ Sleep ☐ Other _____
14. Have you had this problem before?: ◯ No ◯ Yes_____
15. Other Doctors you have seen for this condition: ☐ MD ☐ Neurologist ☐ Orthopedic Surgeon ☐ Chiropractor ☐ Other_____

Dr. Name_____ Diagnosis_____ Were X-rays Taken? ◯ No ◯ Yes Treatment: _____

Physiotherapy/Muscle Therapy? ◯ No ◯ Yes Results, did it help? ◯ No ◯ Yes

16. Date of last Physical Exam:_____Purpose?_____ **Female** are you pregnant? ◯ No ◯ Yes ◯ Unsure

17. What medications are you taking, including over the counter?_____

18. Have you ever:

	No	Yes	Briefly Explain:
Broken bones	☐	☐	
Been hospitalized	☐	☐	
Been in an auto accident	☐	☐	
Had sprains/strains	☐	☐	
Been Struck unconscious	☐	☐	
Had Surgery	☐	☐	

19. Have you ever been under Chiropractic Care? ◯ Y ◯ N Reason?_____

Chiropractor's Name:_____ Date of last visit:_____

20. Are you suffering from any of the following?

3 Months	Over 1 yr.		3 Months	Over 1 yr.		3 Months	Over 1 yr.	
☐	☐	Neck Pain	☐	☐	Mid Back / Shoulder Blade Pain	☐	☐	Low Back Pain
☐	☐	Headaches / Migraines	☐	☐	Asthma / Wheezing	☐	☐	Numbness in Legs / Feet
☐	☐	TMJ	☐	☐	Pain with Deep Breathing	☐	☐	Frequent / Difficulty Urinating / Blood in Urine
☐	☐	Hearing Disturbances	☐	☐	Nausea	☐	☐	Diarrhea
☐	☐	Thyroid Conditions	☐	☐	Indigestion / Heartburn / Reflux	☐	☐	Constipation
☐	☐	Numbness in Arms / Hands	☐	☐	Spitting up Phlegm / Blood	☐	☐	Blood in Stool
☐	☐	Recurrent Cold / Flu	☐	☐	Tired / Irritable	☐	☐	Muscle Cramps in Legs / Feet
☐	☐	Dizziness / Fainting	☐	☐	Recurrent Lung Infection	☐	☐	Injury in Hip / Knee / Ankle
☐	☐	Allergies / Hay Fever	☐	☐	Shortness of Breath	☐	☐	Pain into Hips / Legs / Feet
☐	☐	Tingling in Arms / Hands	☐	☐	Heart Attacks / Angina	☐	☐	Coldness in Legs / Feet
☐	☐	Weakness in Grip	☐	☐	Hardening of Arteries	☐	☐	Recurrent Bladder Infections
☐	☐	Visual Disturbances	☐	☐	Rapid Heartbeat	☐	☐	Tingling in Legs / Feet
☐	☐	Low Energy / Fatigue	☐	☐	Slow Heartbeat	☐	☐	Weak in Legs / Feet
☐	☐	Loss of Consciousness	☐	☐	High Blood Pressure	☐	☐	Swelling of Ankles
☐	☐	Whiplash Injury	☐	☐	Low Blood Pressure	☐	☐	Sciatica
☐	☐	Convulsions	☐	☐	Heart or Blood Diseases	☐	☐	Arthritis
☐	☐	Speech Problems	☐	☐	Pain in Chest / Ribs	☐	☐	Loss of Sleep
☐	☐	Difficulty Swallowing	☐	☐	Hypoglycemia	☐	☐	Cancers: _____
☐	☐	Stroke	☐	☐	Family History of Diabetes	☐	☐	Bone Spurs
☐	☐	Tuberculous	☐	☐	Diabetes	☐	☐	Ulcers / Gastritis
☐	☐	Poor Circulation	☐	☐	Heart Palpitations	☐	☐	Gall Bladder Trouble

Other:_____

21. Do you have any family history of illness?_____

22. Your level of stress at: **Home:** ☐ High ☐ Medium ☐ Low **Work/School:** ☐ High ☐ Medium ☐ Low

23. Are you wearing: ☐ Heel lifts ☐ Prescribed Orthotics ☐ Arch Support

24. Are you taking Nutritional Supplements: ◯ No ◯ Yes _____

25.Describe Your Habits:

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐

PAYMENT IS EXPECTED AT THE TIME OF VIST!

Name of person responsible for Payment_____

I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered will be immediately due and Payable.

I understand that chiropractic does not treat the disease or symptoms but uses them to ascertain where the specific adjustment(s) is/are needed. Chiropractic only attempts to adjust vertebrae, restoring the nerve impulse to the involved tissue, thus allowing the body its best chance of healing itself

Patient / Guardian Signature: _____ **Date:**_____

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

CONSENT TO CHIROPRACTIC TREATMENT

Blackfalds Chiropractic Centre

It is important to consider the benefits, risks and alternatives to treatment. This will help you make an informed decision about proceeding with care.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body. It also includes soft-tissue techniques, therapeutic modalities and exercise.

Benefits - Chiropractic treatment has been shown to be effective for complaints of the neck, back and other areas of the body related to nerves, muscles and joints. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility and improve function.

Risks - The risks associated with chiropractic treatment vary according to each patient's condition and the location and type of treatment. The risks include:

- **Temporary discomfort or worsening of symptoms** – Treatment may cause some discomfort or an increase in pre-existing symptoms of pain or stiffness. This can last a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur with the use of some types of electrical and light therapies. Skin irritation should resolve. A burn may leave a permanent scar.
- **Sprain or strain** – A muscle or ligament sprain or strain may occur. These should resolve within a few days or weeks with rest, minor care and/or protection of the affected area.
- **Rib fracture** – A rib fracture may occur. This can be painful and limit your activity for some time. These usually heal over several weeks with or without further treatment.
- **Disc injury or aggravation** – Some reported cases associate chiropractic treatment with injury or aggravation of a disc condition. This is rare. Spinal discs may degenerate with age or become damaged, with or without symptoms. Signs and symptoms may include neck and back pain, impaired mobility, or radiating pain and numbness into the legs or arms. In severe cases, impaired bowel or bladder function or impaired leg or arm function may occur, which may need surgery.
- **Stroke** – Some reported cases associate chiropractic treatment of the neck with stroke. This is rare. This type of stroke is a serious event involving arteries in the neck and the interruption of blood flow to the brain. The consequences of a stroke can include impairment of vision, speech, balance and brain function, as well as paralysis or death. If signs of stroke occur, seek medical attention immediately.

Alternatives - Alternatives to chiropractic treatment may include consulting other health professionals, over-the-counter pain relievers, rest, and exercise. Each may have their own benefits and risks.

Questions or concerns - Please ask questions at any time about your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time. You are encouraged to be involved in and responsible for your care. Inform your chiropractor immediately of any change in your health or condition.

I acknowledge that I have discussed my condition and the treatment plan with the chiropractor. I understand the nature of the treatment offered to me. I have considered the benefits and risks of treatment and the treatment alternatives. I have read this form or had it read to me. I consent to chiropractic treatment as proposed to me.

Do not sign this form until you meet with the chiropractor.

_____
Patient Name (print)

_____	_____	_____
Patient/Guardian Signature	Date	Chiropractor Signature

Updated: September 2025